

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=63-019524**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **83** Primary Registration District No. **5315** Registrar's No. **7**

**FILED JUN 3 1963**

VS 300  
Rev. 4/59

**10270**

**202702**

**3**

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**1290-3**

**132-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>COOPER</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>COOPER</b>                                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>SALINE TWP</b>   |  | c. CITY OR TOWN <b>PRAIRIE HOME</b>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION   |  | d. STREET ADDRESS (If outside, give location)<br><b>R.F.D. 2</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>KELLY</b> Middle <b>A</b> Last <b>MILLER</b>   |  | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>23</b> Year <b>63</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>NOV 16 1935</b>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>PRAIRIE HOME MO</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>  |   |
| 13a. FATHER'S NAME<br><b>ARCHIE MILLER</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |  | 14. NAME OF HUSBAND OR WIFE<br><b>MAMMIE MILLER</b>  |   |
| 17. INFORMANT<br><b>WILBUR MILLER 814 4TH BOONVILLE</b>  |  | 16. SOCIAL SECURITY NO.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Punches wound brain</b><br>DUE TO (b) <b>Self-inflicted</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>Self-inflicted gunshot wound</b>                                  |   |
| 20c. TIME OF INJURY<br><b>About 5:15 p.m. 5-23-63</b>  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>    |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 20f. CITY, TOWN, OR LOCATION<br><b>Prairie Home</b>  |   |
| 20g. COUNTY<br><b>Cooper</b>   |  | 20h. STATE<br><b>Mo</b>  |   |
| 21. I attended the deceased from _____ to _____<br>Death occurred at <b>about 1 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  | 22a. SIGNATURE<br><b>Dr. DeLoach</b>   |   |
| 22b. ADDRESS<br><b>Boonville Mo</b>  |  | 22c. DATE SIGNED<br><b>5/24/63</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>MAY-27-63</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SPLICE CREEK</b>  | 23d. LOCATION (City, town, or county)<br><b>COOPER MO</b> |
| 24. FUNERAL DIRECTOR<br><b>H T MAY</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 27 1963</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Virginia T. Higgins</b>  |  |  |   |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

JUL 10 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Robert T. May

Licensed Embalmer No. 5221

P. O. Address Bromfield, MA

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.